Ontario

Ministry of Health and Long-Term Care

Inspection Report under the Long-Term Care Homes Act, 2007

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection prévue le Loi de 2007 les foyers de soins de longue durée

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

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Amended Public Copy/Copie modifiée du public de permis

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ Registre no	Type of Inspection / Genre d'inspection
Aug 25, 2016;	2016_200148_0020 (A1)	005712-15, 002183-16 AND 020309-16	Critical Incident System

Licensee/Titulaire de permis

THE CORPORATION OF THE CITY OF CORNWALL
1900 Montreal Rd. CORNWALL ON K6H 7L1

Long-Term Care Home/Foyer de soins de longue durée

GLEN-STOR-DUN LODGE
1900 MONTREAL ROAD CORNWALL ON K6H 7L1

Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs

AMANDA NIXON (148) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

Due to identified delays, the Administrator of the home requested an extension on August 19, 2016 of 60 days. Therefore, the compliance due date has been modified to reflect this request, resulting in a compliance due date to November 30, 2016.

Issued on this 25 day of August 2016 (A1)

Signature of Inspector(s)/Signature de l'inspecteur ou des inspecteurs

Original report signed by the inspector.

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Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs

AMANDA NIXON (148) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): June 24, 27 and 28, 30 and July 4 and 13, 2016.

This inspection included three critical incident inspections, one related to an alleged staff to resident abuse and two related to alleged resident to resident abuse.

During the course of the inspection, the inspector(s) spoke with the home's Administrator, Director of Care (DOC), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), family members and residents.

The Inspector reviewed resident health care records and related documents, the licensee's policy to promote zero tolerance of abuse and neglect of residents and the licensee's investigation notes as available for the critical incidents. The Inspector also observed residents care and services and staff/resident interactions.

The following Inspection Protocols were used during this inspection:

Prevention of Abuse, Neglect and Retaliation

During the course of this inspection, Non-Compliances were issued.

6 WN(s)
3 VPC(s)
1 CO(s)
0 DR(s)
0 WAO(s)

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Legendé WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (A requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA.) The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (Une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with LTCHA, 2007, s. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that resident #002, #003, #004 and #005 were protected from sexual abuse by anyone.

In accordance with O.Reg 79/10 s.2(1), sexual abuse means any non-consensual touching, behaviour or remarks of a sexual nature or sexual exploitation directed towards a resident by a person other than a licensee or staff member.

Resident #002 has a diagnosis of vascular dementia. The most recent Minimum Data Set assessment indicates both decision making and communication deficits. The plan of care for this resident since admission in 2008 has included inappropriate sexual behaviour both verbal or physical related to inappropriate remarks and touching of other residents and/or staff inappropriately. Updates to the plan of care in 2009 and 2015, included to set limits for acceptable behaviour, discourage sexually based interactions, monitor resident on a frequent basis and to remind the resident that relations and any interaction with a certain resident is not allowed. The plan of care also indicates that resident #002 is aware that sexual relations with other residents is not acceptable. After an alleged incident of sexual abuse in early 2016, between resident #002 and resident #001, the plan of care was updated to include half hour checks on resident #002's whereabouts. Approximately one month later, the plan of care was updated to include that when resident #002 is observed to gravitate towards one of the identified resident's room, that resident #002 is to be brought back to his/her room and offered a distraction of music or a movie.

Resident #003 was admitted to the home in the fall of 2015 with a diagnosis of aphasia and unspecified head injury. The most recent Minimum Data Set assessment indicates both decision making and communication deficits. The plan of care for this resident on admission includes inappropriate sexual behaviour verbal or physical related to history of the resident making inappropriate remarks and touching of other residents and/or staff inappropriately. Interventions for this

focus include to distract resident if possible and provide intermittent supervision in recreation programs. In the spring of 2016, the plan of care was updated to include that only a specified gender of staff would be assigned to resident #003's tub bath related to inappropriate comments and touching of staff and to set limits for acceptable behaviour.

In review of a Critical Incident Report (CIR), sent to the Director/MOHLTC, related to the alleged sexual abuse of resident #001 by resident #002 in early 2016, the Inspector discovered the following progress notes since the admission of resident #003:
-on a specified date: resident #002 was touching resident #003 in an inappropriate way;
-on a specified date: resident #002 was touching co residents in an inappropriate way, including rubbing the thigh of resident #003;
-on a specified date: resident #002 was found in the room of resident #003 with his/her hands down the brief of resident #003;
-on a specified date: resident #002 was found in the room of resident #003 on top of resident #003 in his/her bed;
-on a specified date: resident #002 was found in the room of resident #003, resident #003 fondling resident #002;
-on a specified date: resident #002 was being sexually touched by resident #003;
-on a specified date: resident #002 was found fondling resident #003 in his/her room.

As it relates to five of the above described incidents, the residents were separated and/or removed from the situation. Interviews with staff members including RPN #108 and RN #101, indicated that resident #002 was monitored every 30 minutes, the concern both being inappropriate sexual behaviour and the resident's risk of falls due to his/her inability to weight bear and the attempts to transfer him/herself from the wheelchair to the bed of resident #003. Registered and non-registered nursing staff indicated that they will separate the residents when found in resident #003's room or when resident #002 is seen approaching resident #003's room. Staff will provide distraction where possible to prevent resident #002 from engaging with resident #003 in his/her bedroom. During a discussion with three PSWs, it was reported that if the risk of injury was not present they would not separate the residents, as long as the families had given permission. The same PSW staff indicated that the resident's were able to consent and that the touching between the two was not considered abusive.

During discussion of capacity to give consent, to the touching and behaviour as noted in the progress notes, RPN #108 reported that she did not think resident #002 could make these types of decisions and was unsure about the capacity of resident #003. In a similar discussion, RN #101 indicated that resident #002 was capable of giving consent but was not sure if resident #003 had the capacity to give consent.

A mental health assessment dated in early 2016, describes resident #002 with vascular dementia with responsive behaviours, disinhibition and impulsivity. The previous assessment is noted to have been completed in the fall of 2015, due to sexual behaviour toward a new resident, further noting that the new resident also has sexual behaviours, describing the behaviours as potentially reciprocal. Recommendations included that if resident #002 is seen to gravitate towards the above resident, that resident #002 is to be brought back to his/her room to listen to music or watch tv as a form of distraction. The mental consult of early 2016, indicates a review of resident #002's recent behaviours of pursuing co residents and being sexually inappropriate. The impression was that the resident had inappropriate sexual behaviour and recommended an increase to antipsychotic. Further it was the geriatric outreach impression that both resident #002 and co resident have both significant cognitive impairments and do not have the capacity to make an informed decision with regards to sexual relations.

On June 27, 2016, the home's DOC was asked about the interactions between resident #002 and resident #003. The DOC was aware that resident #002 had made attempts to enter the bed of resident #003 that had resulted in falls, that the two sought each other out for companionship and was aware that the two enjoyed holding hands. She noted that the family of resident #003 preferred that resident #002 and resident #003 not be in the same room alone together and for this reason staff were to keep them separated. The DOC explained that mental health has been involved and suggested interventions implemented, that resident #002 does not comply with instructions to stay out of resident #003's room and at one time resident #002 was under half hour checks but she was unsure if this was still in place. The Inspector described the progress notes above indicating touching and behaviour of a sexual nature. The DOC indicated she was not aware of these incidents.

The capacity to provide consent, as it relates to the incidents documented in the progress notes, was discussed with the DOC, who reported that resident #002 was not capable to make decisions about acts of a sexual nature. She further noted that

resident #002 cannot control his/her desires due to his/her diagnosis. With regards to resident #003, she noted that the resident hasn't been saying no to resident #002, that he/she seems to care for resident #002 but she is unsure if resident #003 is able to understand everything that he/she is doing.

During a discussion with the DOC on July 4, 2016, the DOC indicated that they are continuing to look at the possible internal transfer of resident #002, looking at separating resident #002 and resident #003 to reduce the risk. When asked to clarify the risk, the DOC indicated that this is a challenging issue, that the home is looking at options and they are struggling with understanding the capacity of the resident's involved.

On June 28, 2016, the Inspector spoke with both the home's Administrator and DOC. When asked, the Administrator indicated that to his knowledge the resident's had a connection with each other. Through morning meeting discussions he recalled there may be touching (unspecified), holding hands and getting into beds with intent unknown. When asked questions if the capacity to consent, of both resident #002 and #003, had been assessed as it relates to their interactions of a sexual nature, the Administrator noted the home has been reviewing the issue but that there was no evidence to suggest that the two residents didn't like what was going on. He further noted that it was through discussions at morning meetings where it was determined that neither resident exhibited any negative effect and that the interactions were not considered abusive; therefore, the home has been looking at the situation as though they have the capacity to consent. The Inspector reviewed the plans of care for both resident #002 and #003. Neither the Administrator nor DOC could explain the current interventions as it would related to two resident's with capacity to consent and make decisions related to acts of a sexual nature, in particular the plan of care for resident #002 whereby sexual relations with other residents was not acceptable. The Inspector shared the mental health assessment, as described above, although the DOC was aware that the assessment had been completed, neither manager were aware of the details related to the impression of capacity.

The licensee had information available, including a clinical assessment indicating lack of capacity and inhibition, plans of care indicating a history of inappropriate sexual behaviours and interventions in place to encourage separation of the residents. Information available to the licensee suggests that both residents may lack the capacity to give consent to the acts of a sexual nature that are described above. The licensee did not ensure that the capacity of resident #002 and resident

#003 to give consent, were assessed with consideration of all the information available. The licensee having knowledge of touching and behaviours of a sexual nature (i.e. holding hands, unspecified touching, getting into bed), did not have a process in place to effectively monitor the known touching and behaviours of a sexual nature. In this way, the licensee did not ensure that an assessment of capacity of resident #002 and resident #003 to give consent was ongoing and in consideration to each act of a sexual nature. Furthermore, as evidence by interviews with the Administrator, Director of Care and direct care staff members, the licensee did not ensure that the capacity of both residents to consent to interactions of a sexual nature was clearly identified. The failure of the licensee to fully assess and identify the capacity of resident #002 and #003 to consent to acts of a sexual nature, does not ensure the protection of the identified residents from sexual abuse.

During an interview with RPN #108 on June 27, 2016, related to the care and services of resident #002 and resident #003, it was reported that resident #003 has been observed to touch resident #004 inappropriately. Inspector #148 discovered the following progress notes:
-on a specified date: resident #003 was observed to touch resident #005 inappropriately;
-on a specified date: resident #003 was observed to have his/her hand on the groin of resident #004;
-on a specified date, resident #003 was observed to be fondling resident #004.

It was confirmed through review of health care records and observations of resident #004 and #005, in addition to interviews with registered nursing staff and the home's DOC, that neither resident has the capacity to give consent to touching of a sexual nature as described by the progress notes above. Upon review of the critical incident system, used to report matters to the Director such as alleged sexual abuse, no report related to either resident #004 or #005 could be found.

When asked by the Inspector, RN #101 who is a regular day RN, reported that she was not aware of resident #003 being sexually inappropriate with any other residents besides resident #002. The Inspector spoke with three PSW staff members, familiar with the residents on this unit, they indicated they were aware of resident #003 having touched a few residents. PSW #102 reported observing resident #003 touch resident #005 inappropriately and PSW #115 reported having observed resident #003 put his/her hands on resident #004's leg.

On June 27, 2016, the Inspector brought forward the three incidents of alleged sexual abuse involving residents #002, #004 and #005. The DOC reported that she was aware of the incident of the most recent incident involving resident #004, but had not been aware of the other two incidents. The DOC indicated that she had discussed the known incident with the reporting RPN, at the time the home was also in discussion to potentially transfer resident #003 to another floor.

On July 4, 2016, the Inspector spoke with the DOC and asked what action had been taken since June 27, 2016, to protect residents from potential sexual abuse as it relates to resident #003. The DOC reported that the home is monitoring resident #003 with 30 minutes checks and reviewing a possible internal transfer. In addition, a critical incident report submitted July 4, 2016 by the DOC, indicates the home plans to review policies and procedures related to reporting of sexual abuse and education on the topic of sexuality and dementia.

WN #4, demonstrates that the licensee was informed of two incidents of alleged sexual abuse by the Inspector and as of June 30, 2016 the licensee did not ensure the substitute decision makers of resident #004 and #005 were notified within 12 hours.

WN #3, demonstrates that the licensee did not ensure that the Director was informed of an alleged sexual abuse as it relates to the known incident involving resident #004. When asked by the Inspector on June 27th, the DOC reasoned that this incident was not reported to the Director as the incident was not determined to be aggressive or abusive. In addition, the DOC understood that resident #004 did not demonstrate any adverse reaction to the touching and therefore reporting may not have been required.

WN #6, demonstrates that the licensee did not ensure that the police force were notified of the three incidents of alleged sexual abuse involving resident #004 and #005. When asked by the Inspector on July 4, 2016, the DOC indicated that the incident of early 2016 related to the CIR, was reported to the police force as resident #001 had been very vocal and affected by the incident, the same was not the case for residents #004 and #005. The DOC indicated that the capacity of resident #003 was still not understood and that this was a factor of consideration when determining if the police force required notification.

WN #5, demonstrates that measures to monitor the whereabouts of resident #002 included half hour checks. However, during interviews with regularly scheduled

PSWs on this unit, it was determined that such monitoring was informal, without documentation and not necessarily conducted every 30 minutes. In addition to this, findings within this report demonstrate that such monitoring was ineffective in managing the care planned inappropriate sexual behaviour.

The licensee has failed to protect residents #004 and #005 as described by non-compliance within this report. In addition, between the most recent incident of alleged sexual abuse involving resident #004 and June 27,2016, there had been no action, with the exception of an interview with the reporting RPN, to protect residents from potential sexual abuse from resident #003. Interventions to monitor resident #003 every 30 minutes were implemented after the on-site inspection. [s. 19. (1)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

(A1)The following order(s) have been amended:CO# 001

WN #2: The Licensee has failed to comply with LTCHA, 2007, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (2) At a minimum, the policy to promote zero tolerance of abuse and neglect of residents,
(a) shall provide that abuse and neglect are not to be tolerated; 2007, c. 8, s. 20 (2).
(b) shall clearly set out what constitutes abuse and neglect; 2007, c. 8, s. 20 (2).
(c) shall provide for a program, that complies with the regulations, for preventing abuse and neglect; 2007, c. 8, s. 20 (2).
(d) shall contain an explanation of the duty under section 24 to make mandatory reports; 2007, c. 8, s. 20 (2).
(e) shall contain procedures for investigating and responding to alleged, suspected or witnessed abuse and neglect of residents; 2007, c. 8, s. 20 (2).
(f) shall set out the consequences for those who abuse or neglect residents; 2007, c. 8, s. 20 (2).
(g) shall comply with any requirements respecting the matters provided for in clauses (a) through (f) that are provided for in the regulations; and 2007, c. 8, s. 20 (2).
(h) shall deal with any additional matters as may be provided for in the regulations. 2007, c. 8, s. 20 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the policy to promote zero tolerance of abuse and neglect of residents is complied with.

The home's policy to promote zero tolerance of abuse and neglect of residents is titled Resident Non Abuse, policy #MM-0704-08, last revised March 2015. Within the Mandatory Staff Reporting procedure, the policy outlines that in any case of suspected, alleged or witnessed incidents of abuse or neglect causing harm or risk of harm to a resident, the employee or any other person witnessing or having knowledge of an incident must report the incident immediately to their department or immediate supervisor or during evening and night hours to the most senior supervisor available. In any case of suspected resident abuse, the Administrator/Department Supervisor must be notified.

In an interview with the DOC, she described that the expectation is that RPNs with information related to suspected abuse are to report the information to the RN in

charge. The RN would then make a phone call to the Director to report the information and immediately notify either the home's Administrator or herself.

In accordance with O.Reg 79/10 s.2(1), sexual abuse means any non-consensual touching, behaviour or remarks of a sexual nature or sexual exploitation directed towards a resident by a person other than a licensee or staff member

Resident #003 was admitted in the fall of 2015 with a plan of care related to inappropriate sexual behaviours. Resident #002 was admitted in 2008 with a plan of care related to inappropriate sexual behaviours. It was confirmed through review of health care records and observations of resident #004 and #005, in addition to interviews with registered nursing staff and the home's DOC that neither resident has the capacity to give consent to touching of a sexual nature.

During a review of resident #003's progress notes and review of a Critical Incident Report submitted to the Director/MOHLTC, four incidents of alleged sexual abuse were identified as follows:
- on a specified date: a PSW removed resident #002 from the room of resident #001, as resident #001 voiced complaints, admitting to experiencing sexually inappropriate unwanted touch;
- on a specified date: RPN #108 described an incident whereby PSW #102 observed resident #003 touching resident #005 inappropriately;
- on a specified date: RPN #105 described an incident whereby a PSW observed resident #003 to have his/her hand on the groin of resident #004. The PSW immediately moved the resident to another area and there was no further inappropriate touching.

In an interview with the Inspector RPN #105, who was on shift when the first incident occurred, indicated that the report from the PSW was provided to the RN on shift. On the same day, RPN #105 left a voice mail for the DOC regarding the incident. The DOC received the message the next day, at which time action was taken related to the alleged sexual abuse.

As it relates to the other two described incidents above, the Inspector spoke with RPN #105 and RPN #108. It is to their recollection that they would have reported the incidents to the RN, at minimum through the shift report. It was confirmed that the progress notes on the dates of the two incidents were marked for the shift report. In discussion with the home's Administrator and Director of Care, neither were aware of the two incidents, until Inspector #148 brought it to their attention

during the onsite inspection.

As the Department Supervisor, the DOC was not made aware of the incident one incident of alleged sexual abuse until one day after the incident. The Administrator/Department Supervisor were not notified of two incidents of alleged sexual abuse. Registered nursing staff did not follow the policy with regards to reporting incidents of alleged abuse to the Administrator and/or Director of Care.

The licensee failed to ensure that the policy to promote zero tolerance of abuse and neglect of residents, at a minimum , shall contain an explanation of the duty under section 24 to make mandatory reports and shall set out the consequences for those who abuse or neglect residents.

The Inspector reviewed the home's policy to promote zero tolerance of abuse and neglect of residents. The policy includes the duty to make mandatory reports as it relates to s.24(1)2. However, describes that the supervisor must immediately report the incident to the Ministry and that the Administrator/Department Supervisor must notify the Director by way of Critical Incident report within 10 days. The explanation of s.24 to make mandatory reports does not include that a person who has reasonable grounds to suspect abuse immediately report the information to the Director. In addition, the explanation of s.24 does not includes paragraph 1, 3, 4 or 5, as it relates to mandatory reporting of improper or incompetent care, unlawful contact and misuse or misappropriation of resident's money or funding provided to the licensee.

Further, the policy did not set out the consequences for those who abuse or neglect residents. [s. 20. (2)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the policy to promote zero tolerance of abuse and neglect of residents includes an explanation of the duty under s.24 to make mandatory reports and that the policy is complied with, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a person who has reasonable grounds to suspect that abuse or neglect of a resident has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director.

In accordance with O.Reg 79/10 s.2(1), sexual abuse means any non-consensual touching, behaviour or remarks of a sexual nature or sexual exploitation directed towards a resident by a person other than a licensee or staff member.

Resident #003 was admitted in the fall of 2015 with a plan of care related to inappropriate sexual behaviours. It was confirmed through review of health care records and observations of resident #004, in addition to interviews with registered nursing staff and the home's DOC, that the resident has cognitive deficits and does not have the capacity to give consent to touching of a sexual nature.

During a review of resident #003's health care record the Inspector discovered a progress note of a specified date, written by RPN #108 describing an incident whereby resident #003 was found in the dining room fondling resident #004. The RPN spoke with resident #003 that touching of this nature was not acceptable.

During an interview with the DOC on June 27, 2016, she indicated to the Inspector that RPN #108 had made her aware of the incident very soon after the RPN had knowledge of the incident (DOC was not able to establish exactly when).

As of June 27, 2015, the DOC further indicated to the Inspector that no report to the Director had been made. The DOC explained that her interview with the RPN indicated that resident #003 had not been aggressive with the touching and that resident #004 did exhibit any distress. Due to these reasons the Director was not notified of the June 13, 2016, incident. [s. 24. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that a person who has reasonable grounds to suspect that abuse or neglect of a resident has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 97. Notification re incidents

Specifically failed to comply with the following:

s. 97. (1) Every licensee of a long-term care home shall ensure that the resident's substitute decision-maker, if any, and any other person specified by the resident,
(a) are notified immediately upon the licensee becoming aware of an alleged, suspected or witnessed incident of abuse or neglect of the resident that has resulted in a physical injury or pain to the resident or that causes distress to the resident that could potentially be detrimental to the resident's health or well-being; and
(b) are notified within 12 hours upon the licensee becoming aware of any other alleged, suspected or witnessed incident of abuse or neglect of the resident. O. Reg. 79/10, s. 97 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the resident's substituted decision-maker, if any, and any other person specified by the resident, are notified within 12 hours upon the licensee becoming aware of alleged, suspected or witnessed incident of abuse or neglect of the resident.

In accordance with O.Reg 79/10 s.2(1), sexual abuse means any non-consensual touching, behaviour or remarks of a sexual nature or sexual exploitation directed towards a resident by a person other than a licensee or staff member

Resident #003 was admitted in the fall of 2015 with a plan of care related to inappropriate sexual behaviours. It was confirmed through review of health care

records and observations of resident #004 and #005, in addition to interviews with registered nursing staff and the home's DOC, that neither resident has the capacity to give consent to touching of a sexual nature.

During a review of resident #003's progress notes three incidents of alleged sexual abuse were identified as follows:
- on a specified date: RPN #108 described an incident whereby PSW #102 observed resident #003 inappropriately touching resident #005. Resident #003 was told to remove his/her hand and that he/she could not do this.
- on a specified date: RPN #105 described an incident whereby a PSW observed resident #003 to have his/her hand on the groin of resident #004. The PSW immediately moved the resident to another area and there was no further inappropriate touching
- on a specified date: RPN #108 described an incident whereby resident #003 was found fondling resident #004. The RPN spoke with resident #003 that touching of the resident was not acceptable.

On June 27, 2016, the Inspector spoke with the home's DOC, who indicated she had been made aware of the most recent incident involving resident #004 but did not have knowledge of the other two incidents described above. The DOC reported that she had instructed RPN #108 to inform the substitute decision maker (SDM) for resident #004 but could not confirm that this had been completed. During an interview with RPN #108 and review of progress notes it was determined that the SDM for resident #004 was informed of the incident 14 days after the incident.

The Inspector spoke with the SDM for resident #004 on June 30, 2016. The SDM confirmed their knowledge of the most recent incident but stated they were unaware of a second incident involving resident #004.

The Inspector spoke with the SDM for resident #005 on July 4, 2016. The SDM confirmed that they did not have any knowledge of an incident, as described above, involving resident #005.

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the resident's substitute decision-maker is notified within 12 hours upon the licensee becoming aware of alleged, suspected or witnessed incident of abuse or neglect of the resident, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with LTCHA, 2007, s. 6. Plan of care
Specifically failed to comply with the following:

s. 6. (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
2. The outcomes of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
3. The effectiveness of the plan of care. 2007, c. 8, s. 6 (9).

Findings/Faits saillants :

1. The licensee has failed to ensure that the provision of care set out in the plan of care is documented.

Resident #002 was admitted in 2008 and has a diagnosis of vascular dementia. As indicated by interviews with registered nursing staff and the home's DOC, the resident was admitted with known inappropriate sexual behaviours.

The plan of care for resident #002 under the focus of inappropriate sexual behaviors describes that the resident may make inappropriate remarks and touches other residents and/or staff members inappropriately. In early 2016, after an incident of reported alleged sexual abuse, interventions were modified to include that the whereabouts of resident #002 are monitored every ½ hour.

During a review of the progress notes, the Inspector identified six dates whereby the resident was found engaged in touching of a sexual nature with resident #003. On various other dates the resident was found in the room of resident #003, whereby staff would remove resident #002; no touching of a sexual nature described.

Inspector #148 interviewed three PSW staff members who work regularly on the resident's unit. The staff were aware of the intervention to monitor every ½ hour but described that the monitoring may take place every 30-40 minutes or more, noting that the monitoring is informal and conducted whenever they pass the resident's room or walk the unit. Upon review of the resident's health care record and interviews with the PSW staff members, it was determined that the ½ hour checks are not documented. [s. 6. (9) 1.]

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 98. Every licensee of a long-term care home shall ensure that the appropriate police force is immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence. O. Reg. 79/10, s. 98.

Findings/Faits saillants :

1. The licensee has failed to ensure that the appropriate police force is immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence.

Resident #003 was admitted in the fall of 2015 with a plan of care related to inappropriate sexual behaviours. It was confirmed through review of health care records and observations of resident #004 and #005, in addition to interviews with registered nursing staff and the home's DOC, that both residents have cognitive deficits and neither resident has the capacity to give consent to touching of a sexual nature.

During a review of resident #003's progress notes three incidents of alleged sexual abuse were identified as follows:
- on a specified date: RPN #108 described an incident whereby PSW #102 observed resident #003 touching resident #005 inappropriately. Resident #003 was told to remove his/her hand and that he/she could not do this;
- on a specified date: RPN #105 described an incident whereby a PSW observed resident #003 to have his/her hand on the groin of resident #004. The PSW immediately moved the resident to another area and there was no further inappropriate touching
- on a specified date: RPN #108 described an incident whereby resident #003 was found fondling resident #004. The RPN spoke with resident #003 that touching the resident was not acceptable.

During an interview with the DOC on June 27, 2016, she indicated to the Inspector that RPN #108 had made her aware of the most recent incident with resident #004 very soon after the RPN had knowledge of the incident (DOC was not able to establish exactly when). During this same interview the DOC was informed by Inspector #148 of the other two incidents, of which she had no previous

knowledge.

On July 4, 2016, the Inspector spoke with the DOC and inquired if the police force had been notified, to which it was confirmed they had not. When asked the DOC indicated the police had not been notified as the competency of the residents were in question. Upon further discussion the DOC indicated that the police force had not been notified as the residents did not exhibit distress nor appeared to be upset by the incidents.

After the Inspector spoke with the DOC on July 4, 2016, a Critical Incident Report was submitted to the Director/MOHLTC. The report indicates that police were notified of the three incidents as described above. [s. 98.]

Issued on this 25 day of August 2016 (A1)

Signature of Inspector(s)/Signature de l'inspecteur ou des inspecteurs

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the Long-Term Care Homes Act, 2007, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la Loi de 2007 sur les foyers de soins de longue durée, L. O. 2007, chap. 8

Long-Term Care Homes Division
Long-Term Care Inspections Branch
Division des foyers de soins de longue durée
Inspection de soins de longue durée

Ottawa Service Area Office
347 Preston St, Suite 420
OTTAWA, ON, K1S-3J4
Telephone: (613) 569-5602
Facsimile: (613) 569-9670

Bureau régional de services d'Ottawa
347 rue Preston, bureau 420
OTTAWA, ON, K1S-3J4
Téléphone: (613) 569-5602
Télécopieur: (613) 569-9670

Amended Public Copy/Copie modifiée du public de permis

Name of Inspector (ID #) / Nom de l'inspecteur (No) : AMANDA NIXON (148) - (A1)

Inspection No. / No de l'inspection : 2016_200148_0020 (A1)

Appeal/Dir# / Appel/Dir#:

Log No. / Registre no. : 005712-15, 002183-16 AND 020309-16 (A1)

Type of Inspection / Genre d'inspection: Critical Incident System

Report Date(s) / Date(s) du Rapport : Aug 25, 2016;(A1)

Licensee / Titulaire de permis : THE CORPORATION OF THE CITY OF CORNWALL
1900 Montreal Rd., CORNWALL, ON, K6H-7L1

LTC Home / Foyer de SLD : GLEN-STOR-DUN LODGE
1900 MONTREAL ROAD, CORNWALL, ON, K6H-7L1

Name of Administrator / Nom de l'administratrice ou de l'administrateur : Norm Quenneville

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the Long-Term Care Homes Act, 2007, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la Loi de 2007 sur les foyers de soins de longue durée, L. O. 2007, chap. 8

To THE CORPORATION OF THE CITY OF CORNWALL, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (b)

Pursuant to / Aux termes de :

LTCHA, 2007, s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Order / Ordre :

The licensee shall prepare, submit and implement a plan to ensure the following:

-All staff members, including the management team, are educated on the definition of sexual abuse as per O. Reg 79/10 s.2(1)(b),
-Members of the management team, are educated on the LTCHA, 2007 and Ontario Regulation 79/10, related to abuse and neglect of residents specifically: LTCHA s.24(1), O.Reg 79/10 s.97, O.Reg 79/10 s.98
-All staff members are educated on how to identify and report resident to resident sexual abuse, in a manner that ensures compliance with all legislative requirements,
-A process is developed and implemented that describes how the licensee will assess resident's capacity to give consent to each episode of touching, behaviours or remarks of a sexual nature. The process will include, at a minimum, who will be responsible for this assessment, the potential information sources to be used in this assessment and that the assessment must be carried out at the time of each act. In addition, the process will include the monitoring of the resident's fluctuating mental capacity and its impact on the resident's ability to consent to touching, behaviour or remarks of a sexual nature.

In addition, the home shall immediately take steps to ensure that resident #002 and #003 are protected from sexual abuse.

The plan shall be submitted by July 29, 2016 to Amanda Nixon via fax at 613 -569-5602

Grounds / Motifs :

1. 1. The licensee has failed to ensure that resident #002, #003, #004 and #005 were protected from sexual abuse by anyone.

In accordance with O.Reg 79/10 s.2(1), sexual abuse means any non-consensual touching, behaviour or remarks of a sexual nature or sexual exploitation directed towards a resident by a person other than a licensee or staff member.

Resident #002 has a diagnosis of vascular dementia. The most recent Minimum Data Set assessment indicates both decision making and communication deficits. The

plan of care for this resident since admission in 2008 has included inappropriate sexual behaviour both verbal or physical related to inappropriate remarks and touching of other residents and/or staff inappropriately. Updates to the plan of care in 2009 and 2015, included to set limits for acceptable behaviour, discourage sexually based interactions, monitor resident on a frequent basis and to remind the resident that relations and any interaction with a certain resident is not allowed. The plan of care also indicates that resident #002 is aware that sexual relations with other residents is not acceptable. After an alleged incident of sexual abuse in early 2016, between resident #002 and resident #001, the plan of care was updated to include half hour checks on resident #002's whereabouts. Approximately one month later, the plan of care was updated to include that when resident #002 is observed to gravitate towards one of the identified resident's room, that resident #002 is to be brought back to his/her room and offered a distraction of music or a movie.

Resident #003 was admitted to the home in the fall of 2015 with a diagnosis of aphasia and unspecified head injury. The most recent Minimum Data Set assessment indicates both decision making and communication deficits. The plan of care for this resident on admission includes inappropriate sexual behaviour verbal or physical related to history of the resident making inappropriate remarks and touching of other residents and/or staff inappropriately. Interventions for this focus include to distract resident if possible and provide intermittent supervision in recreation programs. In the spring of 2016, the plan of care was updated to include that only a specified gender of staff would be assigned to resident #003's tub bath related to inappropriate comments and touching of staff and to set limits for acceptable behaviour.

In review of a Critical Incident Report (CIR), sent to the Director/MOHLTC, related to the alleged sexual abuse of resident #001 by resident #002 in early 2016, the Inspector discovered the following progress notes since the admission of resident #003:
-on a specified date: resident #002 was touching resident #003 in an inappropriate way;
-on a specified date: resident #002 was touching co residents in an inappropriate way, including rubbing the thigh of resident #003;
-on a specified date: resident #002 was found in the room of resident #003 with his/her hands down the brief of resident #003;
-on a specified date: resident #002 was found in the room of resident #003 on top of resident #003 in his/her bed;

-on a specified date: resident #002 was found in the room of resident #003, resident #003 fondling resident #002;
-on a specified date: resident #002 was being sexually touched by resident #003;
-on a specified date: resident #002 was found fondling resident #003 in his/her room.

As it relates to five of the above described incidents, the residents were separated and/or removed from the situation. Interviews with staff members including RPN #108 and RN #101, indicated that resident #002 was monitored every 30 minutes, the concern both being inappropriate sexual behaviour and the resident's risk of falls due to his/her inability to weight bear and the attempts to transfer him/herself from the wheelchair to the bed of resident #003. Registered and non-registered nursing staff indicated that they will separate the residents when found in resident #003's room or when resident #002 is seen approaching resident #003's room. Staff will provide distraction where possible to prevent resident #002 from engaging with resident #003 in his/her bedroom. During a discussion with three PSWs, it was reported that if the risk of injury was not present they would not separate the residents, as long as the families had given permission. The same PSW staff indicated that the resident's were able to consent and that the touching between the two was not considered abusive.

During discussion of capacity to give consent, to the touching and behaviour as noted in the progress notes, RPN #108 reported that she did not think resident #002 could make these types of decisions and was unsure about the capacity of resident #003. In a similar discussion, RN #101 indicated that resident #002 was capable of giving consent but was not sure if resident #003 had the capacity to give consent.

A mental health assessment dated in early 2016, describes resident #002 with vascular dementia with responsive behaviours, disinhibition and impulsivity. The previous assessment is noted to have been completed in the fall of 2015, due to sexual behaviour toward a new resident, further noting that the new resident also has sexual behaviours, describing the behaviours as potentially reciprocal. Recommendations included that if resident #002 is seen to gravitate towards the above resident, that resident #002 is to be brought back to his/her room to listen to music or watch tv as a form of distraction. The mental consult of early 2016, indicates a review of resident #002's recent behaviours of pursuing co residents and being sexually inappropriate. The impression was that the resident had inappropriate sexual behaviour and recommended an increase to antipsychotic. Further it was the geriatric outreach impression that both resident #002 and co resident have both

significant cognitive impairments and do not have the capacity to make an informed decision with regards to sexual relations.

On June 27, 2016, the home's DOC was asked about the interactions between resident #002 and resident #003. The DOC was aware that resident #002 had made attempts to enter the bed of resident #003 that had resulted in falls, that the two sought each other out for companionship and was aware that the two enjoyed holding hands. She noted that the family of resident #003 preferred that resident #002 and resident #003 not be in the same room alone together and for this reason staff were to keep them separated. The DOC explained that mental health has been involved and suggested interventions implemented, that resident #002 does not comply with instructions to stay out of resident #003's room and at one time resident #002 was under half hour checks but she was unsure if this was still in place. The Inspector described the progress notes above indicating touching and behaviour of a sexual nature. The DOC indicated she was not aware of these incidents.

The capacity to provide consent, as it relates to the incidents documented in the progress notes, was discussed with the DOC, who reported that resident #002 was not capable to make decisions about acts of a sexual nature. She further noted that resident #002 cannot control his/her desires due to his/her diagnosis. With regards to resident #003, she noted that the resident hasn't been saying no to resident #002, that he/she seems to care for resident #002 but she is unsure if resident #003 is able to understand everything that he/she is doing.

During a discussion with the DOC on July 4, 2016, the DOC indicated that they are continuing to look at the possible internal transfer of resident #002, looking at separating resident #002 and resident #003 to reduce the risk. When asked to clarify the risk, the DOC indicated that this is a challenging issue, that the home is looking at options and they are struggling with understanding the capacity of the resident's involved.

On June 28, 2016, the Inspector spoke with both the home's Administrator and DOC. When asked, the Administrator indicated that to his knowledge the resident's had a connection with each other. Through morning meeting discussions he recalled there may be touching (unspecified), holding hands and getting into beds with intent unknown. When asked questions if the capacity to consent, of both resident #002 and #003, had been assessed as it relates to their interactions of a sexual nature, the Administrator noted the home has been reviewing the issue but that there was no

evidence to suggest that the two residents didn't like what was going on. He further noted that it was through discussions at morning meetings where it was determined that neither resident exhibited any negative effect and that the interactions were not considered abusive; therefore, the home has been looking at the situation as though they have the capacity to consent. The Inspector reviewed the plans of care for both resident #002 and #003. Neither the Administrator nor DOC could explain the current interventions as it would related to two resident's with capacity to consent and make decisions related to acts of a sexual nature, in particular the plan of care for resident #002 whereby sexual relations with other residents was not acceptable. The Inspector shared the mental health assessment, as described above, although the DOC was aware that the assessment had been completed, neither manager were aware of the details related to the impression of capacity.

The licensee had information available, including a clinical assessment indicating lack of capacity and inhibition, plans of care indicating a history of inappropriate sexual behaviours and interventions in place to encourage separation of the residents. Information available to the licensee suggests that both residents may lack the capacity to give consent to the acts of a sexual nature that are described above. The licensee did not ensure that the capacity of resident #002 and resident #003 to give consent, were assessed with consideration of all the information available. The licensee having knowledge of touching and behaviours of a sexual nature (i.e. holding hands, unspecified touching, getting into bed), did not have a process in place to effectively monitor the known touching and behaviours of a sexual nature. In this way, the licensee did not ensure that an assessment of capacity of resident #002 and resident #003 to give consent was ongoing and in consideration to each act of a sexual nature. Furthermore, as evidence by interviews with the Administrator, Director of Care and direct care staff members, the licensee did not ensure that the capacity of both residents to consent to interactions of a sexual nature was clearly identified. The failure of the licensee to fully assess and identify the capacity of resident #002 and #003 to consent to acts of a sexual nature, does not ensure the protection of the identified residents from sexual abuse.

During an interview with RPN #108 on June 27, 2016, related to the care and services of resident #002 and resident #003, it was reported that resident #003 has been observed to touch resident #004 inappropriately. Inspector #148 discovered the following progress notes:
-on a specified date: resident #003 was observed to touch resident #005 inappropriately;

-on a specified date: resident #003 was observed to have his/her hand on the groin of resident #004;
-on a specified date, resident #003 was observed to be fondling resident #004.

It was confirmed through review of health care records and observations of resident #004 and #005, in addition to interviews with registered nursing staff and the home's DOC, that neither resident has the capacity to give consent to touching of a sexual nature as described by the progress notes above. Upon review of the critical incident system, used to report matters to the Director such as alleged sexual abuse, no report related to either resident #004 or #005 could be found.

When asked by the Inspector, RN #101 who is a regular day RN, reported that she was not aware of resident #003 being sexually inappropriate with any other residents besides resident #002. The Inspector spoke with three PSW staff members, familiar with the residents on this unit, they indicated they were aware of resident #003 having touched a few residents. PSW #102 reported observing resident #003 touch resident #005 inappropriately and PSW #115 reported having observed resident #003 put his/her hands on resident #004's leg.

On June 27, 2016, the Inspector brought forward the three incidents of alleged sexual abuse involving residents #002, #004 and #005. The DOC reported that she was aware of the incident of the most recent incident involving resident #004, but had not been aware of the other two incidents. The DOC indicated that she had discussed the known incident with the reporting RPN, at the time the home was also in discussion to potentially transfer resident #003 to another floor.

On July 4, 2016, the Inspector spoke with the DOC and asked what action had been taken since June 27, 2016, to protect residents from potential sexual abuse as it relates to resident #003. The DOC reported that the home is monitoring resident #003 with 30 minutes checks and reviewing a possible internal transfer. In addition, a critical incident report submitted July 4, 2016 by the DOC, indicates the home plans to review policies and procedures related to reporting of sexual abuse and education on the topic of sexuality and dementia.

WN #4, demonstrates that the licensee was informed of two incidents of alleged sexual abuse by the Inspector and as of June 30, 2016 the licensee did not ensure the substitute decision makers of resident #004 and #005 were notified within 12 hours.

WN #3, demonstrates that the licensee did not ensure that the Director was informed of an alleged sexual abuse as it relates to the known incident involving resident #004. When asked by the Inspector on June 27th, the DOC reasoned that this incident was not reported to the Director as the incident was not determined to be aggressive or abusive. In addition, the DOC understood that resident #004 did not demonstrate any adverse reaction to the touching and therefore reporting may not have been required.

WN #6, demonstrates that the licensee did not ensure that the police force were notified of the three incidents of alleged sexual abuse involving resident #004 and #005. When asked by the Inspector on July 4, 2016, the DOC indicated that the incident of early 2016 related to the CIR, was reported to the police force as resident #001 had been very vocal and affected by the incident, the same was not the case for residents #004 and #005. The DOC indicated that the capacity of resident #003 was still not understood and that this was a factor of consideration when determining if the police force required notification.

WN #5, demonstrates that measures to monitor the whereabouts of resident #002 included half hour checks. However, during interviews with regularly scheduled PSWs on this unit, it was determined that such monitoring was informal, without documentation and not necessarily conducted every 30 minutes. In addition to this, findings within this report demonstrate that such monitoring was ineffective in managing the care planned inappropriate sexual behaviour.

The licensee has failed to protect residents #004 and #005 as described by non-compliance within this report. In addition, between the most recent incident of alleged sexual abuse involving resident #004 and June 27,2016, there had been no action, with the exception of an interview with the reporting RPN, to protect residents from potential sexual abuse from resident #003. Interventions to monitor resident #003 every 30 minutes were implemented after the on-site inspection. [s. 19. (1)] (148)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le :

Nov 30, 2016(A1)

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the Long-Term Care Homes Act, 2007, S.O. 2007, c. 8

Ministère de la Santé et des Soins de longue durée

Ordre(s) de l’inspecteur

Aux termes de l’article 153 et/ou de l’article 154 de la Loi de 2007 sur les foyers de soins de longue durée, L. O. 2007, chap. 8

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail or by fax upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the Long-Term Care Homes Act, 2007, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la Loi de 2007 sur les foyers de soins de longue durée, L. O. 2007, chap. 8

Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu'il a donné et d'en suspendre l'exécution.

La demande de réexamen doit être présentée par écrit et est signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au titulaire de permis.

La demande de réexamen doit contenir ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le titulaire de permis souhaite que le directeur examine;
c) l'adresse du titulaire de permis aux fins de signification.

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au:

Directeur
a/s Coordinateur des appels
Inspection de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the Long-Term Care Homes Act, 2007, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la Loi de 2007 sur les foyers de soins de longue durée, L. O. 2007, chap. 8

Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.

En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

À l'attention du registraire
Commission d'appel et de révision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto (Ontario) M5S 2T5

Directeur
a/s Coordinateur des appels
Inspection de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

Issued on this 25 day of August 2016 (A1)

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : AMANDA NIXON

Service Area Office /
Bureau régional de services : Ottawa